U.S. Department of Labor

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Issue Date: 03 February 2006

CASE NO.: 2003-BLA-06489

In the Matter of

JIM SENTERS
Claimant

v.

HOLSTON MINING CO.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-interest

Appearances:

LEONARD J. STAYTON, Esq.
For Claimant

LOIS A. KITTS, Esq.
For Employer

Before:

JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

On August 5, 2003, this case was referred to the Office of Administrative Law Judges ("OALJ") for a formal hearing. Subsequently, the case was assigned to me. I held a formal hearing on May 11, 2005, in Pikeville, Kentucky, at which time the parties had full opportunity to present evidence and argument.[1]

I. ISSUES

(1) Whether Claimant has pneumoconiosis;

(2) Whether Claimant's pneumoconiosis arose out of coal mine employment; and

(3) Whether Claimant is totally disabled due to pneumoconiosis.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Jim Senters ("Claimant") filed a claim for benefits under the Federal Black Lung Act dated August 2, 2001. DX-2. On August 8, 2001, the Office of Workers' Compensation Programs ("OWCP") claims examiner determined that Holston Mining Company ("Employer") was the responsible operator in this case. DX-17. Notice to Employer was sent on that date. DX-18. The parties were then given the opportunity to submit evidence and on May 5, 2003, the OWCP District Director ("Director") issued a Proposed Decision and Order on the matter. DX-39. Relying on the reading of a Department of Labor ("DOL") X-ray, dated September 22, 2001, by Dr. Glen Baker, M.D., the Director found that Claimant had established all four elements of a Black Lung claim and was therefore entitled to benefits under the Act. Id. The Director also found that Holston Mining Company was the liable responsible operator and that Claimant had established a total of thirty-seven years of coal mine employment. Id. Employer disagreed with the Director's award of benefits to Claimant and on May 20, 2003, filed a request for a formal hearing before the Office of Administrative Law Judges ("OALJ"). DX-41. Consequently, on May 28, 2003, the Director notified Employer that the claim would be forwarded to the OALJ for a formal hearing. DX-42.

On August 5, 2003, this matter was referred to the OALJ for a formal hearing. DX-46. The hearing was originally scheduled before ALJ Daniel F. Solomon for July 22, 2004, in Pikeville, Kentucky. However, on July 12, 2004, Employer moved for a continuance in this matter. The motion was not objected to and ALJ Solomon, by Order dated July 15, 2004, granted the continuance and Ordered the hearing cancelled. The case was subsequently referred to me and I issued a second Notice of Hearing, dated February 10, 2005, in which I rescheduled the formal hearing to be held on May 11, 2005, in Pikeville, Kentucky. I also Ordered that the parties must submit pre-hearing statements in order for the hearing to commence. The formal hearing was conducted as scheduled, at which time evidence was entered into the record and

[1] In this Decision and Order, "DX-#" refers to Director's Exhibits; "CX-#" refers to Claimant's Exhibits; "EX-#" refers to Employer's Exhibits and "Tr. at -" refers to the Hearing Transcript of May 11, 2005.

Claimant's testimony was taken. Employer subsequently filed a post-hearing brief in the matter.[2]

Upon review of the evidence, I note that Employer submitted deposition testimony from Dr. Alexander Poulos (DX-32). I find that this testimony was submitted contrary to the regulations, as the testimony was not offered in compliance with § 725.414(c), which anticipates testimony from a physician who prepared a medical report or whose testimony is offered in lieu of a medical report. Pursuant to § 725.414(a)(1), "a medical report consists of a physician's written assessment of miner's respiratory or pulmonary condition" and "[a] physician's written assessment of a single objective test, such as a chest X-ray or a pulmonary function test, shall not be considered a medical report." 725.414(a)(1). Dr. Poulos did not prepare a medical report within the meaning of the regulations, but rather interpreted objective tests. His testimony cannot be considered a medical report, and therefore, is not permissible. Parenthetically, if I were to consider the testimony admissible, then the testimony would be construed as one of Employer's two permitted medical reports, thereby eliminating from my consideration the evidence from other medical experts whose opinions were offered by Employer, and who testified by deposition.

Although no objection was raised to the admission of the deposition testimony of Dr. Poulos, medical evidence that exceeds the limitations imposed by § 725.414 may not be considered, even where the parties have agreed to the admission of excessive medical evidence. *Smith v. Martin County Coal Corporation*, BRB No. 04-0126 BLA (Oct. 27, 2004), (to be published at 23 BLR 1-). *See also Phillips v. Westmoreland Coal Co.*, BRB No. 04-0379 BLA (Jan. 27, 2005, unpub.) Accordingly, I have not considered the testimony of Dr. Poulos in this adjudication.

B. Factual Background

Before Claimant testified at the hearing, the parties entered into a stipulation that Claimant has had at least thirty years of coal mine employment. Tr. at 5, 36. The Director had found that Claimant had thirty-seven years of coal mine employment. Tr. at 37. I accept the stipulation of the party, and find that it is supported by the record.

1) Claimant's Testimony

Claimant was born on July 17, 1935, and was sixty-nine years old at the time of the hearing. His only dependant is his spouse, Geraldine Senters. Claimant's educational background consisted of completing the twelfth grade. Tr. at 37.

When Claimant first filed his application for benefits, he disclosed that his last employer was Pitston Coal Company. Tr. at 37. Claimant testified that Piston Coal Company is the same company as the named responsible operator, Holston Mining Company. Tr. at 38. Claimant began working with Employer in 1990 and ceased in July of 2000 because he was old enough to retire and he couldn't "get [his] breath." Tr. at 38. His last job for Employer was heavy

[2] The following citation denotes the Post-Hearing Brief on Behalf of Holston Mining Company dated September 7, 2005: "EB at -."

equipment operator and he also repaired preparation plants. Tr. at 38. The latter job consisted of changing motors or screens and at times it required more than 100 pounds of lifting. Tr. at 39. Claimant testified that his work for Employer was a surface operation but he had previously worked in deep mines and he opined that the coal dust at Employer was worse than his underground work. Tr. at 39. He has not worked for wages since he left the mines in July of 2000. Tr. at 40.

Claimant testified that he has had problems breathing for fifteen years, and takes oxygen to help his breathing problem. Tr. at 40. He has been treated by Dr. Hussain for the last three months. Tr. at 41. Claimant currently takes a breathing capsule once a day, uses an inhaler, and inhales another powder medication. Tr. at 41. He testified that this treatment does help his breathing. Tr. at 41.

Besides his lung problems, Claimant also has a heart problem, a hiatal hernia, and high blood pressure. Tr. at 42. In addition, he has had two mild heart attacks. Tr. at 42. He currently takes a blood thinner prescription once a day and a blood pressure medication twice a day for these problems. Tr. at 42-43. His hiatal hernia has caused some swallowing problems which have caused him to seek care at the hospital. Tr. at 43. Claimant testified that he could only walk about an eighth of a mile on level ground before stopping to take a breath. Tr. at 43. He also can lift no more than between twenty and fifty pounds. Tr. at 44. Claimant can mow his lawn with a riding lawnmower but cannot do the trim work with a weed eater because of his condition. Tr. at 44. Claimant also has a difficult time sleeping because of his condition. Tr. at 45.

Claimant testified on direct-examination that he chewed on a cigar years ago but never really "smoked." Tr. at 45. On cross-examination he testified that he "smoked and chewed on a cigar…smoked on them a little bit." Tr. at 47. He has smoked one cigar a day, three or four days a week for two or three years. Tr. at 47. On redirect examination, Claimant testified that he never inhaled the cigars. Tr. at 48.

2) Relevant Medical Evidence

Dr. Glen R. Baker, Jr., M.D., F.C.C.P. (DX-12; CX-7)

Dr. Glen Baker, M.D., is a NIOSH certified B-Reader and a Board-certified pulmonary specialist. CX-14. At the request of the DOL, Dr. Baker performed a pulmonary evaluation of Claimant on September 22, 2001. DX-12. At that time, Dr. Baker had a chest X-ray performed on Claimant and he interpreted it as Category 1/0 positive. Dr. Baker also conducted an arterial blood gas study, an EKG, and a pulmonary function study. The pulmonary function study disclosed a moderate obstructive defect. Based on his findings, specifically his chest X-ray interpretation and Claimant's history of coal dust exposure, Dr. Baker concluded that Claimant has an occupational lung disease which was caused by his coal mine employment. He categorized the extent of Claimant's pulmonary impairment as moderate but noted that the pulmonary function studies were not reproducible. He also noted that any such impairment may be related to coal dust exposure. Dr. Baker concluded the report by opining that Claimant does

not have the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment. Dr. Baker notes a FEV_1 of 57% as the rationale for that opinion.

Dr. Baker also wrote a report dated November 6, 2003 in which he affirmed his conclusion that Claimant has an occupational lung disease which was caused by his coal mine employment. CX-7. He referred to Claimant's long history of coal dust exposure and a chest X-ray consistent with coal workers' pneumoconiosis as the basis for his diagnosis. Dr. Baker categorized Claimant's pulmonary impairment as moderate but considered that assessment questionable because the pulmonary function studies were not reproducible. Dr. Baker opined that since Claimant is a non-smoker, any pulmonary impairment would probably be related to his coal dust exposure. Dr. Baker concluded the report with his opinion that Claimant does not have the respiratory capacity to perform coal mine work or comparable work in a dust-free environment. Dr. Baker noted that the pulmonary function studies are not reproducible but do show a moderate obstructive defect. Dr. Baker expressed his concern that it is unclear whether the observed moderate obstructive defect was due to patient effort or breathing problems that made it difficult to perform the test adequately. Dr. Baker concluded that he would "err on the conservative view point that [Claimant] should probably have no further exposure to coal dust, rock dust or similar noxious agents."

Dr. Alexander Poulos, M.D. (DX-28; DX-29; DX-32; EX-9)

Dr. Alexander Poulos is a Board-certified radiologist and a Niosh certified B-Reader. CX-32; EX-14. He is also the senior radiologist at the Pikeville Methodist Hospital. On September 11, 2002, Dr. Poulos reviewed the October 25, 2001 X-ray of Claimant's chest, and reported that the film was completely negative. Dr. Poulos' impression was that there was no evidence of pneumoconiosis. DX-28. On that same day, Dr. Poulos also reread the September 22, 2001 X-ray and found it completely negative, with no evidence of pneumoconiosis. DX-29.

Dr. Timothy E. Dineen, M.D. (CX-1)

Dr. Timothy Dineen is a Board-certified radiologist. CX-16. Dr. Dineen had the opportunity to review the September 2, 2003 X-ray film the day after it was performed. CX-1. He reported that the film indicated a few scattered small nodular opacities throughout both lungs consistent with coal workers' pneumoconiosis. His impression was that his X-ray findings were "suggestive of coal worker's pneumoconiosis."

Dr. Thomas E. Miller, M.D. (CX-2; CX-4; CX-5; CX-17)

Dr. Thomas E. Miller, M.D., is Board-certified in Diagnostic Radiology and is a NIOSH certified B-Reader. CX-12. The record consists of five submissions by Dr. Miller. On July 10, 2003, Dr. Miller read the September 22, 2001 X-ray film and interpreted it as Category 2/1 positive for pneumoconiosis. CX-4. He stated that his findings of multiple small irregular and round opacities ranging in size up to approximately 3 mm was consistent with pneumoconiosis. Id. Then, on June 30, 2004, Dr. Miller read the October 25, 2001 X-ray film and interpreted it as Category 1/1 positive for pneumoconiosis. CX-2. He stated on this report that his findings of multiple small irregular and round opacities ranging in size up to approximately 1.5 mm were

consistent with pneumoconiosis. Id. On June 30, 2004, Dr. Miller also reviewed a CT scan of Claimant's chest taken on October 25, 2001 and found that the CT scan showed slightly increased diffuse interstitial lung markings on Claimant's lungs. CX-5. His impression was that such an interstitial lung disease was compatible with simple pneumoconiosis. Id. On June 23, 2005, Dr. Miller had the opportunity to read the September 2, 2003 X-ray as well as the March 19, 2005 X-ray. He interpreted both X-rays as Category 1/1 positive for pneumoconiosis. CX-17. His findings in each case were that the X-rays indicated multiple bilateral small irregular and round opacities ranging in size up to approximately 3 mm. His impression was that in each case those findings were consistent with pneumoconiosis. CX-17.

Dr. John W. West, M.D. (CX-3)

Dr. John West is a Board-certified radiologist. CX-15. Dr. West read the October 25, 2001 X-ray the day after it was performed, and found that it demonstrated "a fine reticulonodular parenchymal disease." CX-3. The doctor then opined that his findings are "quite subtle and are suspicious for pneumoconiosis." His final impression was that pneumoconiosis cannot be excluded from his review of the X-ray.

Dr. Enrico John Cappiello, M.D. (CX-6)

Dr. Enrico Cappiello is Board-certified in diagnostic radiology. CX-13. On July 1, 2004, Dr. Cappiello reread the October 25, 2001 CT scan of Claimant's chest. CX-6. Dr. Cappiello's impression was that the CT scan indicated chronic obstructive pulmonary disease and scattered small opacities consistent with underlying pneumoconiosis.

Dr. Intiaz Hussain, M.D. (CX-8; EX-8)

The record contains a letter from Dr. Intiaz Hussain dated April 12, 2005. CX-8. Dr. Hussain is Claimant's treating physician and Claimant has proffered this letter as one of his two affirmative medical reports. TR. at 23. The handwritten letter states that Claimant is "disabled from pneumoconiosis from coal dust exposure and is unable to do work comparable to his original occupation." CX-8.

Employer also submitted into evidence the results of a pulmonary function study performed by Dr. Hussain on March 30, 2005 and the results of an arterial blood gas study performed on March 15, 2005. EX-8.

Treatment Records of Dr. Angco (CX-9)

CX-9 includes treatment records of Dr. Angco dated from January 29, 1997 through July 2001. Tr. at 23.

Dr. Ghazala Quddus, M.D. (CX-10; CX-11)

CX-10 includes a discharge summary from Williamson Memorial Hospital for the period of May 28, 2002 through May 31, 2002. Tr. at 24. The report is signed by Dr. Quddus, who saw Claimant at his office for treatment of epigastric pain and chest pain. CX-10

Dr. Quddus, a treating physician, filed a report dated May 13, 2002. CX-11. Dr. Quddus documented Claimant's patient history and performed a physical examination. Under the section of the report headed "PULMONARY," Dr. Quddus notes that Claimant has coal workers' pneumoconiosis.

Dr. Bruce C. Broudy, M.D. (EX-1; EX-2; EX-6)

Dr. Bruce Broudy is a NIOSH certified "B"-Reader and a pulmonary specialist. EX-10. Dr. Broudy was deposed in this matter on May 16, 2005 by counsel for Employer. The doctor evaluated Claimant on October 25, 2001 and filed a report dated April 18, 2005. EX-2 at 6. Dr. Broudy's evaluation consisted of documentation of Claimant's occupational history, a physical examination, spirometry testing, lung volume testing, an arterial blood-gas study, chest X-rays, and a CT scan. EX-2 at 7. Dr. Broudy testified that Claimant had a sufficient history within which a susceptible individual could contract coal workers' pneumoconiosis. EX-2 at 7. However, his physical examination of Claimant's chest revealed the lungs to be clear; the chest X-ray was negative for pneumoconiosis; and the blood-gas study was normal for his age. EX-2 at 8. Dr. Broudy testified that the results of the spirometry testing did exceed the minimum federal criteria for disability in coal workers and the lung volumes suggested air trapping as might be found in obstructive airways disease or emphysema. EX-2 at 8. Dr. Broudy, however, noted that the spirometry was performed with variable and less than optimal effort. EX-2 at 8. Dr. Broudy found that the CT scan he reviewed showed an abnormality of emphysematous blebs throughout both lungs but the doctor explained that this type of abnormality is not related to the inhalation of coal-mine dust but is related to pulmonary emphysema which can be a result of aging. EX-2 at 9. Dr. Broudy's final opinion was that Claimant was not totally disabled from a respiratory standpoint. EX-2 at 9. Dr. Broudy had the opportunity to view the reports of Dr. Hussain, Dr. Angco, and Dr. Quddus and stated that the reports of those physicians would not change his opinions concerning Claimant's condition. EX-2 at 9.

Dr. Abdul K. Dahhan, M.D., F.C.C.P. (EX-3; EX-4; EX-15)

Dr. Abdul Dahhan is a pulmonary specialist and NIOSH certified B-Reader. EX-11. He examined Claimant on March 19, 2005 and filed a report dated March 25, 2005. EX-3. Dr. Dahhan was deposed in this matter on April 19, 2005. EX-3, EX-4

Dr. Dahhan's evaluation of Claimant included an occupational and medical history, a physical exam, pulmonary function studies, arterial blood gas studies, and a chest X-ray. EX 4 at 5. Dr. Dahhan reported that the physical examination of Claimant's chest showed good air entry to both lungs with no crepitation, rhonci or wheeze, while the electrocardiogram showed regular sinus rhythm. The X-ray that the doctor performed showed clear lungs with no pleural or parenchymal abnormalities consistent with pneumoconiosis. Dr. Dahhan classified the film as

Category 0/0 in his narrative report and deposition and checked off that the film is completely negative on the standardized DOL X-ray report form.

Dr. Dahhan also reported that the spirometry tests showed a mild restrictive ventilatory defect with an FVC of 69% of predicted and FEV_1 of 66% predicted. Dr. Dahhan opined that the spirometry studies were compatible with a pattern of non-parenchymal restrictive ventilatory abnormalities secondary to that seen in patients who suffer from obesity or other chest wall abnormalities. In his deposition, Dr. Dahhan testified that in this case, Claimant's lungs are being squashed by the excessive weight that he has. EX-3, EX-4 at 7. He further testified that the blood-gas study he performed on Claimant confirmed that type of abnormality. Dr. Dahhan then discussed that in his opinion, Claimant has a mild respiratory impairment due to his excessive weight, not severe enough to be disabling in nature. EX-3, EX-4 at 7. Dr. Dahhan stated that Claimant is about fifty pounds overweight and that excessive weight on the chest wall can make it difficult for the lungs to expand. EX-3, EX-4 at 7.

In his narrative report, Dr. Dahhan mentioned that he reviewed the medical records of Dr. Baker and Dr. Poulos in conjunction with his examination of Claimant. Based on his review of the past medical records and his examination of Claimant, Dr. Dahhan concluded that: (1) there were insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis, (2) there were no objective findings to indicate any total or permanent pulmonary disability, and (3) from a respiratory standpoint, Claimant retains the physiological capacity to continue his previous coal mining work or job of comparable physical demand with no evidence of pulmonary impairment and/or disability related to coal workers' pneumoconiosis.

During his deposition, Dr. Dahhan disclosed that he recently had the opportunity to review Dr. Hussain's report dated April 12, 2005. Dr. Dahhan opined that Dr. Hussain's report is "entirely subjective." EX-4 at 8. He stated that while Dr. Hussain noted Claimant's shortness of breath, he failed to document any objective findings to indicate significant respiratory impairment to support the notion of pulmonary impairment. EX-4 at 8. Dr. Dahhan also opined that at the present time he would not recommend oxygen as a treatment for Claimant. EX-4 at 8.

Dr. Jerome F. Wiot, M.D. (EX-5)

Dr. Jerome Wiot is a Board-certified radiologist and a NIOSH certified B-Reader. (EX-12), who reviewed Claimant's chest X-ray of September 2, 2003. EX-5. Dr. Wiot explained in a report, dated March 28, 2005, that the X-ray revealed "very few 'q' and 't' sized opacities…but the degree of profusion is no more than 0/1." EX-5. Dr. Wiot then explained that a profusion of 0/1 is a negative diagnosis for coal workers' pneumoconiosis.

Dr. Matthew A. Vuskovich, M.D., M.S.P.H. (EX-7)

Dr. Matthew Vuskovich is a NIOSH certified B-Reader and is board certified in occupational medicine. EX-13. Dr. Vuskovich reviewed the pulmonary function study performed by Dr. Baker on December 14, 2001. EX-7. Dr. Vuskovich's ultimate opinion is that the spirometry results from that test are not valid and should not be used in formulating disability decisions because he concluded that the test was not conducted with Claimant's maximum effort.

The doctor cites Dr. Baker's statement, "Patient did not produce consistent effort," as support for his opinion.

Williamson ARH Hospital (EX-8)

EX-8 contains the results of an arterial blood gas study performed at Williamson Appalachian Regional Healthcare Hospital on March 15, 2005.

C. Entitlement

Because this claim was filed subsequent to January 19, 2001, Claimant's entitlement to benefits will be evaluated under the revised regulations set forth at 20 C.F.R. Part 718. Benefits are provided under the Act for miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a). "Pneumoconiosis" is defined as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201(a). In order to establish entitlement to benefits under Part 718, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3a) the miner it totally disabled, and (3b) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Colliers, 512 U.S. 267 (1994).

1) Whether Claimant Suffers from Pneumoconiosis

Determining the Existence of Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§ 718.202(a)(1) through (a)(4):

(1) X-ray evidence: § 718.202(a)(1).

(2) Biopsy or autopsy evidence: § 718.202(a)(2).

(3) Regulatory presumptions: § 718.202(a)(3):

> (a) § 718.304 - Irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.
>
> (b) § 718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.
>
> (c) § 718.306 - Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971.

and

(4) Physician's opinions based upon objective medical evidence § 718.202(a)(4).

The record contains the following § 718.202(a) evidence:

(1) Chest X-Ray Evidence - § 718.202(a)(1).

Under § 718.202(a)(1), the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with § 718.102.[3] It is well-established that the interpretation of an X-ray by a B-reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985); Martin v. Director, OWCP., 6 B.L.R. 1-535, 537 (1983). The Benefits Review Board ("BRB") has also held that the interpretation of an X-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). In addition, a judge is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

The current record contains the following chest X-ray evidence:

Date of X-Ray	Date Read	Exhibit No.	Physician	Radiological Credentials	Film Quality	Interpretation
(1)						
9/22/01	9/22/01	DX-12	Baker	B-Reader	3	1/0
9/22/01	10/30/01	DX-13	Sargent	B-Reader; BCR	2	Read for quality only
9/22/01	9/11/02	DX-29	Poulos	B-Reader; BCR	2	Completely negative
9/22/01	7/10/03	CX-4	Miller	B-Reader; BCR	2	2/1
(2)						
10/25/01	10/25/01	EX-1	Broudy	B-Reader	1	0
10/25/01	10/26/01	CX-3	West	BCR	n/a	Suspicious for pneumoconiosis
10/25/01	9/11/02	DX-28, 32	Poulos	B-Reader; BCR	2	Completely negative
10/25/01	06/30/04	CX-2	Miller	B-Reader;	2	1/1

[3] A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51 A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii) (2001).

				BCR		
10/25/01	07/30/04 (date of report)	EX-6[4]	Broudy	B-Reader	1	Negative
(3)						
09/02/03	9/03/03	CX-1	Dineen	BCR	n/a	Findings suggestive of pneumoconiosis
09/02/03	03/28/05	EX-5	Wiot	B-Reader; BCR	1	0/1
09/02/03	06/23/05	CX-17	Miller	B-Reader; BCR	1	1/1
(4)						
03/19/05	03/19/05	EX-3	Dahhan	B-Reader	1	0/0
03/19/05	06/23/05	CX-17	Miller	B-Reader; BCR	1	1/1

The preceding table demonstrates that there were four X-rays of Claimant's chest entered into evidence. The first X-ray was taken on September 22, 2001, as part of a DOL evaluation. It was first read on that day by the examining physician, Dr. Glen R. Baker, M.D., who is a B-Reader but not a Board-certified radiologist. He interpreted the X-ray as positive for pneumoconiosis with an I.L.O. profusion category of 1/0. It was next read for quality by Dr. E. Nicholas Sargent, M.D., who concluded that the film was of acceptable quality. Dr. Alex Poulos, M.D., who is both a B-Reader and a Board-certified radiologist, read the first X-ray on September 11, 2002. Dr. Poulos concluded that the X-ray was completely negative for pneumoconiosis. The first X-ray was last read by Dr. Thomas E. Miller, M.D., who is both a B-Reader and a Board-certified radiologist. Dr. Miller interpreted the X-ray as positive for pneumoconiosis with an I.L.O. profusion category of 2/1.

Dr. Miller and Dr. Poulos are both dually qualified as B-Readers and Board-certified radiologists. Their interpretations of the first X-ray are sharply contrasted. Dr. Miller interpreted the X-ray as Category 2 and positive for pneumoconiosis (meaning numerous small opacities indicated) while Dr. Poulos interpreted the X-ray as completely negative. Dr. Baker, on the other hand, interpreted the X-ray as 1/0 positive (meaning small opacities definitely present but few in number). Since Dr. Miller's interpretation of a positive X-ray is corroborated by Dr. Baker's positive interpretation, I find that the September 22, 2001 X-ray is positive for pneumoconiosis.

The next X-ray of record was taken on October 25, 2001 and performed by Dr. Bruce C. Broudy. Dr. Broudy, a B-Reader, interpreted the X-ray as Category 0 and negative for pneumoconiosis. Three other physicians also read the October 25, 2001 X-ray. Dr. John W. West, M.D., a Board-certified radiologist, read the X-ray the day after it was performed and found it "suspicious for pneumoconiosis." The next physician to interpret the X-ray was Dr.

[4] EX-6 is a report by Dr. Bruce C. Broudy, M.D., in which he affirms his original interpretation of the 10/25/01 X-ray found in EX-1.

Alex Poulos, M.D., on September 11, 2002. Dr. Poulos, who is dually qualified, found that the X-ray was completely negative. Subsequently, Dr. Thomas E. Miller, who is also dually qualified, read the X-ray on June 30, 2004, and interpreted it as Category 1/1 positive. On July 30, 2004, Dr. Broudy was given the opportunity to reevaluate the X-ray after reviewing the reports of Drs. West and Miller. Dr. Broudy affirmed his earlier findings on that report.

The evidence reflects that the October 25, 2001 X-ray was interpreted as negative by one dually qualified physician and positive by another. Both physicians' interpretations were corroborated by another non-dually qualified physician. Dr. West, who is a Board-certified radiologist, corroborated Dr. Miller's positive interpretation and Dr. Broudy, who is a B-Reader, corroborated Dr. Poulos' negative interpretation. Although these physicians are not dually qualified, each has special qualifications with respect to reading X-rays, and I therefore decline to accord more weight to the opinion of either. However, Dr. West merely opines that the X-ray is "suspicious for pneumoconiosis." I find this opinion vague and equivocal, and decline to accord it substantial weight. For those reasons, I find that Dr. Poulos' negative interpretation is better supported than Dr. Miller's positive interpretation. Accordingly, I find that the October 25, 2001 X-ray is negative for pneumoconiosis.

The third X-ray in the record is dated September 2, 2003. Dr. Timothy Dineen, M.D., a Board-certified radiologist, read the X-ray the day after it was performed and his impression was that the X-ray was suggestive of pneumoconiosis. Dr. Wiot, a B-reader and Board-certified radiologist, had the opportunity to read the X-ray on March 28, 2005, and interpreted it as Category 0/1 negative. On June 23, 2005, Dr. Thomas Miller read the X-ray and interpreted it as Category 1/1 positive.

The September 2, 2003 X-ray was interpreted as positive by one dually qualified physician and negative by another dually qualified physician. A third physician, who is not a B-reader, found that the X-ray was "suggestive of pneumoconiosis." Dr. Dineen's interpretation, while suggestive, is clearly not conclusive on the issue. He notes in his report that there are a few scattered small nodular opacities consistent with pneumoconiosis but fails to state an I.L.O. category. In contrast, Drs. Miller and Wiot were both able to determine I.L.O. categories. Since Drs. Miller and Wiot both have superior qualifications to Dr. Dineen and their conclusions are more completely detailed and documented, I find that Dr. Dineen's X-ray interpretation is worth little weight. Accordingly, since two dually qualified physicians conflicted on their interpretations of the X-ray film, I find that the evidence regarding the September 2, 2003 X-ray is in equipoise and does not establish the existence of pneumoconiosis.

The final X-ray in the record is dated March 19, 2005, and was performed by Dr. Abdul Dahhan. Dr. Dahhan, who is a B-reader, interpreted the X-ray film as completely negative for pneumoconiosis. In contrast, on June 23, 2005, Dr. Thomas Miller, who is both a B-Reader and a Board-certified radiologist, had the opportunity to review that X-ray film and interpreted it as Category 1/1 positive. Since Dr. Miller has superior qualifications to Dr. Dahhan, I accord his interpretation more weight. Accordingly, I find that the March 19, 2005 X-ray is positive for pneumoconiosis.

Weighing all of the X-ray evidence together, I find that it demonstrates that the Claimant suffers from pneumoconiosis. There are four X-rays on record. I have found that two X-rays are positive while one is negative and the fourth is in equipoise. Accordingly, I find that the preponderance of the X-ray readings suggest that Claimant suffers from pneumoconiosis.

(2) Biopsy or Autopsy Evidence - § 718.202(a)(2).

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is unavailable here, because the current record contains no such evidence.

(3) Regulatory Presumptions - 718.202(a)(3).

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. § 718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

(4) Physicians' opinions - § 718.202(a)(4).

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth as follows in subparagraph (a)(4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.204(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis." Section 718.201 (a)(1) and (2) defines clinical pneumoconiosis and legal pneumoconiosis. Section 718.201(b) states:

> [A] disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

The current record contains the following physicians' opinions:

Dr. Glen Baker performed a pulmonary evaluation of Claimant at the request of the DOL. Dr. Baker's report diagnoses Claimant with a lung disease caused by coal mine employment and lists a long history of dust exposure and chest X-ray (X-ray of 09/22/01) findings consistent with coal workers' pneumoconiosis as the basis of that diagnosis. CX-7. Dr. Baker also stated that Claimant is a non-smoker and it was his opinion that any pulmonary impairment is "probably" related to his coal dust exposure. Id.

Dr. Intiaz Hussain opined that Claimant is "disabled from pneumoconiosis from coal dust exposure and is unable to do work comparable to his original occupation" in his handwritten report dated April 12, 2005. CX-8. Because of the report's handwritten nature, it is difficult to ascertain from it what Dr. Hussain's opinion is based on. It can be inferred from CX-8 itself that Dr. Hussain at least relied upon an employment history of 40(?) years in the coal mines for his opinion. In addition, EX-9 demonstrates that Dr. Hussain may have conducted an arterial blood gas study dated March 15, 2005, conducted a pulmonary function test dated March 30, 2005 and reviewed a chest X-ray on March 15, 2005. However, the record does not contain direct evidence linking the reports in EX-9 to the opinion found in CX-8.

Dr. Bruce Broudy was deposed on May 16, 2005. He testified that in his opinion, Claimant "was not totally disabled from a respiratory standpoint." EX-2. at 9. Dr. Broudy based this opinion on an examination of Claimant which included an occupational history, a physical examination, spirometry testing, lung volume testing, an arterial blood gas study, a chest X-ray and a review of a CT scan. Dr. Broudy testified that the chest X-ray of October 25, 2001 was Category 0 negative for pneumoconiosis. In addition, Dr. Broudy testified that although the CT scan he reviewed revealed emphysematous blebs throughout both lungs, this type of abnormality on a CT scan was not related to the inhalation of coal mine dust but, was rather related to pulmonary emphysema which can be a result of aging.

Dr. Abdul Dahhan performed an evaluation of Claimant that included occupational and medical histories, a physical exam, pulmonary function studies, arterial blood gas studies, and a chest X-ray. Dr. Dahhan had found that the physical examination of Claimant's chest had showed good air entry to both lungs and he interpreted the March 19, 2005 X-ray as Category 0/0. Based on these clinical findings, as well as his review of Claimant's other medical records, Dr. Dahhan reported that "there were insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis." EX-3.

A medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). An opinion that is based on a physical examination, symptoms and a patient's work and social histories may be found to be adequately documented. Hoffman v. B & G Construction Co., 8 B.L.R. 1-65 (1985). A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields, *supra*. A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Company, 12 B.L.R. 1-149 (1989).

In the case at hand, I find that the opinions of Drs. Baker, Broudy, and Dahhan are all well-documented and well-reasoned. Those physicians submitted reports which disclosed that each of them performed comprehensive pulmonary evaluations of Claimant. Their reports contain both their clinical findings and supported medical conclusions. In contrast, the report of Dr. Hussain is but a one page handwritten letter. Although the record contains other evidence that suggests that Dr. Hussain's medical opinions are supported by clinical findings, I decline to credit Dr. Hussain's opinion with great weight on the basis of inference. There is direct link between Dr. Hussain's conclusion of coal workers' pneumoconiosis (CX-8) and objective testing. Accordingly, I give the reports of Drs. Baker, Broudy, and Dahhan more weight in my assessment of the evidence than the report of Dr. Hussain.

20 C.F.R. § 718.107: "Other Medical Evidence"

In addition to the § 718.202(a) evidence discussed above, the regulations permit an ALJ to give appropriate consideration to "the results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate the presence or absence of pneumoconiosis." § 718.107(a). The burden is on the party submitting the "other medical evidence" to demonstrate its medical acceptability and relevancy in determining entitlement to benefits. § 718.107(b).

Both parties in this case have submitted readings of a CT scan of Claimant's chest performed on October 25, 2001. Dr. Thomas Miller reported that his June 30, 2004 reading of the CT scan revealed a few tiny nodular capacities and interstitial lung disease both compatible with simple pneumoconiosis. CX-5. Dr. Enrico Cappiello reported that his July 1, 2004 reading of the CT scan revealed chronic obstructive pulmonary disease and scattered small opacities consistent with underlying pneumoconiosis. CX-6. Dr. Bruce Broudy reported that his October 25, 2001 reading of the CT scan revealed multiple emphysematous blebs throughout both lungs but no evidence of coal workers' pneumoconiosis. EX-1. Dr. Alexander Poulos reported that his September 11, 2002 reading of the CT scan revealed mild emphysematous changes in the mid and upper lung zones but no evidence of small or large opacities compatible with coal workers' pneumoconiosis. EX-9.

The record thus contains two consistent negative readings of the CT scan evidence and two consistent positive readings. I therefore find that the CT scan evidence is in equipoise and the presence of pneumoconiosis has not been established based on CT scan evidence.

Penn Allegheny Balancing Test

The Third Circuit has held that, in considering whether the presence of pneumoconiosis has been established, "all types of relevant evidence must be weighed together to determine whether the claimant suffers from the disease." Penn Allegheny Coal Co. v. Williams, 114 F.3d 22, 25 (3d Cir. 1997).

After balancing all of the relevant medical evidence together, I find that Claimant has established the presence of coal workers' pneumoconiosis. As I previously stated, the chest X-ray evidence weighs in Claimant's favors while the CT scan evidence is non-conclusive for

either party. After reviewing the physicians' opinion evidence on record, I find that Dr. Baker's is the most reliable on the issue of presence of pneumoconiosis. Dr. Baker performed an impartial pulmonary evaluation at the request of the DOL. His conclusion of coal workers' pneumoconiosis was based both on a positive X-ray reading and Claimant's long history of coal mine employment. Dr. Baker was then afforded a second opportunity to review his evaluation and again found the presence of pneumoconiosis. It is therefore well-documented and well-reasoned. Without discrediting the opinions of Drs. Broudy and Dahhan, I credit Dr. Baker's opinion on the issue of presence of pneumoconiosis more weight because it is better supported by the weight of the chest X-ray evidence as a whole. As such, I find his opinion on the presence of pneumoconiosis to be the most reliable.

Accordingly, based on the weight of the chest X-ray evidence and the credited opinion of Dr. Baker, I find that Claimant has established the presence of pneumoconiosis.

2) Whether the Pneumoconiosis "Arose Out of" Coal Mine Employment

The Regulations mandate that in order for a claimant to succeed on a claim for benefits under the Act, "it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment." 20 C.F.R. § 718.203(a). There is a rebuttable presumption that the pneumoconiosis arose out of coal mine employment if a miner who is or was suffering from pneumoconiosis was employed for ten years or more in one or more coal mines. 20 C.F.R. § 718.203(b).

In the case at hand, Employer has stipulated to thirty years of coal mine employment. Tr. at 5. This stipulation is sufficient to trigger the rebuttable presumption of § 718.203(b). Since Employer has offered no evidence or argument to rebut the presumption, I find that Claimant has established that his pneumoconiosis "arose out of" coal mine employment.

3) Whether the Claimant is Totally Disabled Due to Pneumoconiosis

In addition to the presence of pneumoconiosis, in order for Claimant to prevail, he must establish that he is totally disabled due to a respiratory or pulmonary condition. Total disability is defined in § 718.204(b)(1) as follows:

> A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner (i) [f]rom performing his or her usual coal mine work; and (ii) [f]rom engaging in [other] gainful employment in a mine or mines.

§718.204(b)(1). Non-pulmonary and non-respiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. §718.204(a). Additionally, § 718.204(a) provides that:

> If, however, a non-pulmonary or non-respiratory condition or disease causes a chronic respiratory or pulmonary impairment,

that condition shall be considered in determining whether the miner is or was totally disabled [under the Act].

Claimant may establish total disability in one of four ways: (1) pulmonary function study; (2) arterial blood gas study; (3) evidence of cor pulmonale with right-sided congestive heart failure; or (4) reasoned medical opinion. §§ 718.204(b)(2)(i)-(iv). A presumption of total disability is not established by a showing of evidence qualifying under a subsection of § 718.204(b)(2), but rather such evidence shall establish total disability in the absence of contrary evidence of greater weight. Gee v. W.G. Moore & Sons, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. Rafferty v. Jones & Laughlin Steel Corp., 9 B.L.R. 1-231 (1987).

(1) Pulmonary Function Studies

In order to demonstrate total respiratory disability on the basis of pulmonary function study evidence, a claimant may provide studies, which, after accounting for sex, age, and height, produce a qualifying value for the FEV1 test, and produce either a qualifying value for the FVC test or the MVV test, or produce a value of FEV1 divided by the FVC less than or equal to 55 percent. "Qualifying values" for the FEV1, FVC and the MVV tests are measured results less than or equal to values listed in the appropriate tables of Appendix B to 20 C.F.R. Part 718, 20 C.F.R. § 718.204(b)(2)(i). Director, OWCP v. Simiec, 894 F.2d 635, 637 n.5, 13 B.L.R. 2-259 (3rd. Cir 1990).

The record contains the pulmonary function studies ("PFSs") summarized below:

Date	EX. No.	Physician	Age/ Ht.	FEV_1	FVC	MVV	FEV_1/FVC	Effort	Qualifies
09/22/01	DX-12	Baker	66 73"	2.22	4.16	65	53%	Fair	**YES** FEV_1/FVC < 55%
10/25/01	EX-1	Broudy	66 74"	3.31 1.64*	3.42 2.80*	60 61*	68% 59%	Vary	**NO** **YES*** FEV_1: 2.27 FVC: 2.91 MVV: 91
12/14/01	DX-12	Baker	66 73"	2.16	3.38	69	64%	Fair	**YES** FEV_1: 2.21 FVC: 2.83 MVV: 88
03/19/05	EX-3	Dahhan	69 72"	2.41 2.43*	3.32 3.28*	70 75*	73% 74%*	Fair	**NO** FEV_1: 2.07 FVC: 2.66 MVV: 83

* post bronchodilator

The PFS performed by Dr. Baker on September 22, 2001 produced a qualifying value because the FEV_1/FVC value rendered was less than 55%. Dr. Baker noted on that report, however, that Claimant "was unable to produce acceptable and reproducible spirometry data"

because of dyspnea. DX-12. Because of the stated concerns of Dr. Baker as to the acceptability of the spirometry data, I find that the September 22, 2001 PFS is invalid in determination of this claim. This conclusion is further supported by Claimant's improved performance in a test administered just one month later, in October, 2001. It has been recognized that in this effort-dependent test, disparately higher values tend to be more reliable than low values. See, Andruscavage v. Director, OWCP, No. 93-3291 (3rd Cir. 1994) (unpublished slip op.).

The PFS performed by Dr. Broudy on October 25, 2001 produced non-qualifying values before a bronchodilator was administered but produced qualifying values after the bronchodilator was administered. Dr. Broudy noted that the decrease in the results after dilation was "clearly effort related." EX-1. Accordingly, I find that the qualifying values produced on this test are unreliable.

The PFS performed by Dr. Baker on December 14, 2001 produced a qualifying value because the reported FEV_1 value (2.16) was less than the Appendix B FEV_1 qualifying value (2.21) and the reported MVV value (69) was less than the Appendix B MVV qualifying value (88). Dr. Baker noted after the results of that PFS that Claimant "did not produce consistent tracings." DX-12. Subsequently, Dr. Matthew Vuskovich reviewed the results of the second PFS performed by Dr. Baker and reported that the results were invalid due to lack of maximum effort. EX-7. Because of the stated concerns of Dr. Baker and the invalidation of the results by Dr. Vuskovich, I find that the December 14, 2001 PFS is invalid for the determination of this claim.

The PFS performed by Dr. Dahhan on March 19, 2005, did not produce a qualifying FEV_1 value and thus does not establish total disability.

After invalidating the PFSs performed by Dr. Baker, the record is left with one non-qualifying PFS and a PFS that is non-qualifying pre-bronchodilator and qualifying post-bronchodilator. Both Dr. Baker and Dr. Broudy noted concerns about Claimant's effort in performing the studies. In addition, it has been recognized that pneumoconiosis is a progressive and irreversible disease, and it may be appropriate to accord greater weight to the most recent evidence of record. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989)(en banc). Moreover, the most recent test produced higher values than were produced on earlier tests, and therefore, those lower values are specious. For these reasons, I accord greater weight to the results of Dr. Dahhan's PFS and find that the pulmonary function study evidence does not support a finding that Claimant is totally disabled.

(2) Arterial Blood Gas Studies

To establish total disability based on Arterial Blood Gas Studies, the test must produce the totals presented in the Appendix C to 20 C.F.R. Part 718, 20 C.F.R. § 718.204(b)(2)(ii).

The record contains the arterial blood gas studies ("ABGs") summarized below:

Date	EX. No.	Physician	Altitude	pCO_2	pO_2	Qualifies[5]
09/15/00	CX-10	Fernandez	0 – 2999 ft.	26	68	YES (74)
09/22/01	DX-12	Baker	0 – 2999 ft.	33	91	NO (67)
10/25/01	EX-1	Broudy	0 – 2999 ft.	35.6	75.8	NO (64)
05/28/02	CX-10	Quddus?	0 – 2999 ft.	31	67	YES (69)
03/19/05	EX-3	Dahhan	0 – 2999 ft.	31.1 31.7*	84.6 77.5*	NO (69) NO (68)

* Measured at the end of exercise

After review of the ABG evidence, I find that it does not establish that Claimant is totally disabled. The two qualifying ABGs found at CX-10 were performed while Claimant was hospitalized at Williamson Memorial Hospital. I question the reliability of these studies because they are part of hospital discharge reports and are not accompanied by any explanations or interpretations. Further, the May 28, 2002 ABG was performed at the hospital at the request of Dr. Quddus. However, Dr. Quddus makes no mention of the ABG testing in his report found at CX-11 which diagnoses Claimant with coal workers' pneumoconiosis. Because of the vagueness of these two ABGs, I accord them less probative value than the other tests. The other three ABGs conducted, including the one performed by the DOL impartial examiner, Dr. Baker, produced non-qualifying results. Accordingly, I find that Claimant has not established that he is disabled based upon the arterial blood gas evidence.

(3) Cor Pulmonale Diagnosis

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided heart failure. 20 C.F.R. § 718.204(b)(2)(iii).

There is no evidence of cor pulmonale with right-sided congestive heart failure in the record. Accordingly, I find that Claimant has not established total disability under § 718.204(b)(2)(iii).

(4) Reasoned Medical Opinion

The final method for determining total disability is through the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful employment. Such an opinion must be based on acceptable clinical and laboratory diagnostic techniques. 20 C.F.R. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Field v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (BRB 1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (BRB 1989).

[5] In order to qualify for total disability under arterial blood gas studies, Claimant's pO_2 value would have to be equal to or lower than the given pO_2 levels found in the "Qualifies" column of this chart.

There are four medical opinions in this case with regard to whether Claimant is totally disabled due to pneumoconiosis.

In his report, Dr. Intiaz Hussain states that Claimant is "disabled from pneumoconiosis from coal dust exposure and is unable to do work comparable to his original occupation." CX-8. That report contains no clinical findings or observations of Dr. Hussain, but is a conclusory observation by the doctor. I find that Dr. Hussain's medical opinion is not well-reasoned and I accord it little probative value. I have considered Dr. Hussain's status as Claimant's treating physician. In considering whether a treating physician's opinion is entitled to controlling weight, I must consider the nature of the physician-patient relationship and its duration, and the frequency and extent of treatment. 20 C.F.R. section 178.104(d)(1)-(4). I decline to give controlling weight to Dr. Hussain as Claimant's treating physician because the record does not provide sufficient evidence regarding the extent of his treatment, and because other record evidence contradicts the opinions of Dr. Hussain. 20 C.F.R. section 718.204(d)(5).

Dr. Baker also opined that Claimant was disabled and unable to return to coal mine employment or comparable work. Dr. Baker based his finding of disability on the qualifying pulmonary function studies he performed which he found to reveal a moderate obstructive defect. However, Dr. Baker himself noted that those pulmonary function studies were not reproducible and that it was unclear whether the results were due to patient effort. He first noted "questionable" next to the categorization of Claimant's pulmonary impairment as moderate and then expressly noted, "I would err on the conservative view point that he should probably have no further exposure to coal dust, rock dust or similar noxious agents." CX-7. It is clear that Dr. Baker is not convinced that the results of the pulmonary function testing show a disabling impairment. Further, the December 14, 2001 pulmonary function test relied upon by Dr. Baker was later invalidated by Dr. Vuskovich, whose opinion I accord substantial weight on this issue. I therefore find that Dr. Baker's opinion as to total disability, which is based largely on irreproducible pulmonary function results, is entitled to little weight.

Dr. Broudy performed a pulmonary evaluation of Claimant that included a pulmonary function study and a CT scan. During his deposition, Dr. Broudy testified that the results of the spirometry testing did exceed the minimum federal criteria for disability in coal mine workers; however, he first noted that the study was performed with variable and less than optimal effort. He then attributed Claimant's lung volumes results to obstructive airways disease or emphysema. Dr. Broudy also testified that he found abnormalities on the CT scan he performed. He disclosed that the CT scan revealed emphysematous blebs which are not related to the inhalation of coal mine dust but to pulmonary emphysema, which can be a result of aging. When asked whether Claimant is disabled from a respiratory or pulmonary standpoint, Dr. Broudy replied, "I felt he was not totally disabled from a respiratory standpoint." Dr. Broudy never opined as to whether Claimant could return to coal mine employment.

Dr. Dahhan also performed a pulmonary evaluation of Claimant. At his deposition, he testified that the results of the spirometry tests he performed revealed a non-parenchymal mild ventilatory defect. Dr. Dahhan explained that this type of abnormality is seen in patients who suffer from obesity. In his opinion, Claimant suffers from a mild respiratory impairment due to his excessive weight, that is not severe enough to be disabling in nature. Dr. Dahhan's report

states that "[f]rom a respiratory standpoint, [Claimant] retains the physiological capacity to continue his previous coal mining work or job of comparable physical demand." I have accorded substantial weight to the results of the test performed by Dr. Dahhan. I find his opinion that Claimant does not have a disabling respiratory condition is well-documented and supported by the objective test. Dr. Dahhan's opinion on this issue is entitled to significant weight.

The clinical bases for Dr. Baker's opinion that Claimant is totally disabled are pulmonary function studies that have non-reproducible results, and which I have found to be invalid. In his report, Dr. Baker noted his concern about patient effort in performing the study, which concern was corroborated by Dr Broudy. Dr. Broudy attributed the difference between non-qualifying results on a PFS before a bronchodilator and qualifying results after to patient effort. Thus, evidence of Claimant's lack of optimal effort during spirometry testing is corroborated by separate physicians in separate tests. Dr. Broudy specifically testified that such effort could produce distorted results, which I find to be borne out by the results of the test he conducted. Further, Dr. Baker expresses his uncertainty as to Claimant's disability in his report where in addition to categorizing Claimant's pulmonary impairment as moderate, Dr. Baker noted "Questionable, PFT's not reproducible." When asked whether the impairment is related to pneumoconiosis, Dr. Baker noted, "…it is felt that any pulmonary impairment is probably related to his coal dust exposure." Finally, Dr. Baker reports that he would "err on the conservative view point" that Claimant should no longer be exposed to coal dust. Dr. Baker's opinion regarding whether the Claimant is disabled and if so, by what cause, are equivocal and not reliable. The only other physician to opine that Claimant is totally disabled is Dr. Hussain but his opinion is not well-documented and is conclusory. Thus, I do not view it as corroborating Dr. Baker's opinion.

Dr. Broudy testified at his deposition that it was his opinion that Claimant was not "totally disabled." However, I give no probative weight to Dr. Broudy's use of the legal phrase, totally disabled. Since he never testified whether or not Claimant could return to coal mine employment, it is too speculative to infer what his actual opinion would be as to that issue. Dr. Broudy did find some evidence of disability on a CT scan and pulmonary function testing but he attributed it to pulmonary emphysema rather than pneumoconiosis. He firmly concluded that there was no evidence of disease caused by, aggravated by, or related to the inhalation of coal dust. I cannot find that Dr. Broudy's opinion in this case is corroborated by Dr. Dahhan. Like Dr. Broudy, Dr. Dahhan also found evidence of mild respiratory impairment. In contrast though, Dr. Dahhan attributed it to obesity rather than aging. There is no mention of obesity as a significant factor of diagnosis in Dr. Broudy's report or testimony.

I find that Claimant has not established by a preponderance of the medical opinion evidence that he is totally disabled.

Considering all of the evidence together, I further find that it fails to establish that Claimant is totally disabled under the Act.

Assuming arguendo, however, that the medical evidence was able to establish that Claimant was totally disabled, I find that Claimant has not established by a preponderance of the evidence that his total disability is related to coal workers' pneumoconiosis. Although I have

found that Claimant has established the presence of pneumoconiosis, it was done so by heavily crediting the positive X-ray and CT scan interpretations of the dually qualified radiologist, Dr. Thomas Miller. Although Drs. Baker, Broudy, and Dahhan are in agreement that there exists evidence of some type of respiratory impairment, they each provide inapposite opinions as to its etiology. Dr. Broudy attributes a finding of emphysematous blebs to aging while Dr. Dahhan attributes a mild respiratory impairment to obesity. Dr. Baker notes in his report that "any pulmonary impairment is *probably* related to his coal dust exposure." (Emphasis added). Dr. Baker's finding of pneumoconiosis was based on the reading of one X-ray which he interpreted to be category 1/0 positive. A category 1/0 interpretation is the minimum reading under the regulations that will support a finding of pneumoconiosis. Because Dr. Baker's report contains hesitant language as to the etiology of Claimant's disability, as well as reliance on an invalid pulmonary function study and an X-ray reading establishing minimal evidence of pneumoconiosis, I accord it less probative weight in the matter. As such, I find that even if Claimant had been successful at establishing total disability, he would have failed to establish that his total disability is related to pneumoconiosis.

Accordingly, I find that the preponderance of the evidence does not establish that Claimant is totally disabled due to a pulmonary condition related to coal workers' pneumoconiosis.

III. CONCLUSION

Based upon my review of all of the evidence, I find that Claimant has established the presence of pneumoconiosis. However, Claimant has not established that he is totally disabled due to a pulmonary or respiratory condition arising out of his coal mine employment.

IV. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this claim, the Act prohibits the charging of any fee to Claimant for representation services rendered in pursuit of the claim.

ORDER

The claim of JIM SENTERS for benefits under the Act is hereby DENIED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).